Psychological & Counseling Associates

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Children and Adolescent Information Form

Completion of the following pages assists us in efficiently providing you with quality care. The information obtained is protected within the constraints of the individual treatment and standards governing confidentiality.

Date_____ Home Phone_____

IDENTIFYING DATA

Name_____ Nick Name _____

Date of Birth_____ Age _____

Address _____

City_____ State _____ Zip _____

Parents' Name _____ Parents' Work Number _____

Parents' Marital Status _____ Sex: M _____ F _____ Occupation _____

Teacher's Name _____ School _____

Grade _____ Is the child in L.D. Classes? _____ has there been any testing done? _____

When _____ Where_____

Are there any educational problems: _____ Please list: _____

_____

Please list all of the information regarding individuals who live with you currently:

Name Sex Age Relationship to Client

_____

_____

_____

_____

_____

_____

Whom may we thank for referring you? _____

What is it you want to gain by coming here? _____

Have you ever been given psychological tests? Yes ___ No___ If yes, when and where were they given? _____

_____

Have you ever received mental health services in the past? Yes ___ No___

If yes, what where some of the concerns? _____

_____

_____

BEHAVIORAL HEALTH DATA

What are your leisure activities/interests? _____

What do you do for recreation? _____

_____

Do you have sleep difficulties? Yes ___ No ___ If yes, explain_____

Current medical problems: _____

_____

Please list all currently prescribed psychotropic medications: _____

_____

Current Difficulties: (Please check all that apply to you)

___Restless	___ Eating Too Much	___ Smoking Too Much
___ Argue A Lot	___ Disobedient	___ Crying A Lot
___ No Appetite	___ Teases others	___ Stomach Aches
___ Worrying A lot	___ Impulsive	___ Lying
___ Headaches	___ Stealing	___ Nightmares
___ Feeling Lonely	___ Brags, boasts	___ Bullies, threatens others
___ Anxious/Afraid	___ Tired All the Time	___ Tense, unable to relax
___ Afraid of Failing	___ Wanting To Hurt Others	___ Anxious
___ Losing Temper Easy	___ Aggressive	___ Feeling Hopeless
___ Feels Inferior	___ Avoiding People	___ Messy, sloppy
___ Feeling Confused	___ Smokes	___ Lies
___ Fights	___ Putting Things Off	___ Destroying Things
___ Feeling Guilty	___ Wanting To Run Away	___ Selfish
___ Withdraws from others	___ Depressed, always sad	___ Hyperactive
___ Sulks, pouts	___ Temper tantrums	___ Feelings easily hurt
___ Uses drugs	___ Cheats	___ Uses alcohol
___ Cruel to others	___ Runs away from home	___ Absent mindedness
___ Suicidal Ideation	___ Sexual Abuse	

PERSONAL RESOURCES

My strengths and best features are _____

_____

The most important thing that happened to me in the past year: _____

_____

The most important thing that happened to me in my life: _____

_____